STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155152	B. WING			02/22/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			MAIN ST		
MONTIC	ELLO ASSISTED L	LIVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000						•	
F0000	State Licensur Survey dates: 21, and 22, 20 Facility number Provider number: AIM number: Survey team: Lara Richards Brenda Buroke Amber Bloss, William "Christ Surveyor Janelyn Kulik, (2/22/13) Census bed ty SNF/NF: 92	February 18, 19, 20, 213 er: 000072 per: 155152 100287440 , RN, TC er, RN Medical Surveyor " Greeney, Medical RN	F000	00	The creation and submission this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Des Review in lieu of a post survey revisit on or after March 24, 20	of of old	
	Residential: 9						
	Census payor Medicare: 16 Medicaid: 58 Other: 27 Total: 101 These deficier	type: ncies reflect state in accordance with 410					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155152	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 02/22	E SURVEY LETED 2/2013
	PROVIDER OR SUPPLIER EELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CO MAIN ST CELLO, IN 47960	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Quality review completed on March 1, 2013, by Janelyn Kulik, RN.				

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Event ID: 2XHN11

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AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:			
		A. BUILDING		00	COMPLETED
		155152	B. WING		02/22/2013
			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROV	VIDER OR SUPPLIER		1120 N	MAIN ST	
MONTICELL	LO ASSISTED LI	VING AND HEALTHCARE		CELLO, IN 47960	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	183.20(b)(1)				
		'E ASSESSMENTS			
	•	onduct initially and			
		prehensive, accurate,			
	each resident's fu	oducible assessment of			
	acii iesideiit s idi	ictional capacity.			
Δ	A facility must mal	ke a comprehensive			
		esident's needs, using the			
		ent instrument (RAI)			
		tate. The assessment			
	nust include at lea	•			
		demographic information;			
	Customary routine; Cognitive patterns;				
	Communication;	,			
	/ision;				
	Mood and behavio	or patterns;			
	sychosocial well-				
P	Physical functioning	ng and structural			
	oroblems;				
	Continence;				
	•	s and health conditions;			
	Dental and nutritions;	onai status;			
	Activity pursuit;				
	Medications;				
		s and procedures;			
	Discharge potentia				
	Documentation of	summary information			
		itional assessment			
		care areas triggered by			
	•	the Minimum Data Set			
	MDS); and Documentation of	participation in			
	assessment.	participation in			
_		rvation, interview and	F0272		03/24/2013
		he facility failed to	1 02 / 2	F 272 Comprehensive Assessment	
		•			
		s were thoroughly			
		e use of psychoactive			
dı	rugs for 4 of 1	0 residents reviewed		It is the practice of this provider to	

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Event ID: 2XHN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED 02/22/2013		
		155152	B. WIN			02/22/2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			MAIN ST CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ry medication use. 7, #61, #65, and #131)			ensure that residents are thorough assessed for the use of psychoact	- I
	(11001001110 1101	, 1101, 1100, and 11101)			drugs.	
	Findings includ	de:				
	Observation and interview of				What corrective action(s) wil	I
					be accomplished for those	
	Resident #87 on 2/18/13 at 2:00 p.m., indicated the resident was alert to person, place and time. The resident				residents found to have been	1
					affected by the deficient practice?	
	' '	propriately to several				
	questions and provided good insight					
	to answers.	,			Decidents #07 #04 en	
					Residents #87, #61 and #65 have been thoroughly	
	The resident's	record was reviewed			assessed for the use of	
	on 2/20/13 at 1	11:00 a.m., and			psychoactive drugs.	
	indicated the re	esident was admitted to			D :1 1 1/404	
	the facility in Ju	uly 2012, with the			 Resident #131 no longe resides in the facility. 	ır
	1	uding, but not limited			resides in the facility.	
	to, dementia w	rith behavioral			· The consultant pharmacist	
	disturbance, de	ementia with delusions,			reviewed Residents #87, #61, #65, a #130 medications to ensure that th	
	depression and	d anxiety. The			are free from unnecessary drugs,	еу
	Physician orde	ers, indicated the			making recommendations as neede	d.
	1	ed Risperdal (an			. Posidonts #97 #64 #65 an	_
	anti-psychotic	medication) 0.25			Residents #87, #61, #65, and #130 medication regimens are	u
	milligrams (mg) in the morning,			reviewed routinely for a gradual dos	e
	, , ,	mg in the evening and			reduction as required per state regulation.	
		ntidepressant) 10 mg			. ogulation:	
	every day.					
	The Admission	n Minimum Data Set			How will you identify other	
		ment, dated 8/1/12,			residents having the potentia	al
	, ,	ef Interview for Mental			to be affected by the same	
		of 13 of 15, indicating			deficient practice and what corrective action will be take	n?
	, ,	ive deficit. The MDS			Solitotive action will be take	"'
	indicated the re					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLE	ETED
		155152	B. WIN			02/22/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		1	MAIN ST		
MONTIC	FLLO ASSISTED I	IVING AND HEALTHCARE			CELLO, IN 47960		
					T	ı	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	behavior or mo	ood problems and				1	
		sychotic drugs and an			· All residents who receive a		
	antidepressant seven days a week.				psychoactive drug have the potentia	l to	
	antidepressant seven days a week.				be affected by the alleged deficient practice.		
	The 10/27/12	and 1/18/13 Quarterly			produce.		
	The 10/27/12 and 1/18/13, Quarterly MDS assessments, indicated a BIMS				· A consultant pharmacist		
					reviews each resident's medication regimen routinely but no less than		
	,	cognitive deficit) and			monthly to ensure that they are free		
		or mood problems. ontinued to receive			from unnecessary drugs, making		
					recommendations as needed.		
	antipsychotic drugs and an antidepressant seven days a week.				Before any resident receives	a	
	anddepressan	i seven days a week.			new order for a psychoactive drug th		
	On 2/22/13 at 11:00 a.m., the				will be thoroughly assessed by the physician for the use of the medicati	on	
		·			priyerelari for the dee of the medical		
		ector was informed of			· Social Services and the		
		egarding the continued			Interdisciplinary team will review	the	
		choactive drugs and			psychoactive medication use within first 5 days of admission to determin		
		additional information			past and present behaviors/moods		
	available.				exhibited, and appropriate diagnosis and indication for use.	;	
		100/40 4 4 4 00			and maleation for dee.		
		/22/13 at 11:30 a.m.,			A comprehensive care plan		
		Nursing was informed			be created for assessment and track of the medication.	king	
		thorough assessment			of the medication.		
		use of the psychoactive			· Social Services will audit the	:	
		uested any additional			Gradual Dose Reduction tracker on	а	
	information av	allable.			routine basis.		
	0.00000	4.00 " 0 1 1			Social Services will review c	are	
		1:30 p.m., the Social			plans for residents using psychoacti		
		or provided behavior			medication for continued indication fuse and placement.	OI	
	flow sheets which were blank as well						
		D of the MDS for			· Social Service is		
		er information was			responsible to review resident		
	l ·	licate the resident			behaviors with the Interdisciplinary Team at the		
		rough assessment for			clinical meeting Monday-Frida	v l	
	the use of the	psychoactive			(excluding holidays). The	,	
	medications.				resident's plan of care is revie	wed	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
(E 0E P			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEI	R	1120	N MAIN ST	
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE	MON	TICELLO, IN 47960	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
				and revised, as needed. Significant resident behaviors reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident neare met.	
				The Charge Nurse is responsible to follow-up on consultation orders as needed.	1.
				The Interdisciplinary Team reviews Physician Orders and the 2-Hour Report, to ensure pertinent orders referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on dut notified by the charge nurse of pertinformation on the weekends and holidays, as needed.	ders y is
				What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	nto
				The interdisciplinary team we re-educated on Psychotropic Medicause on 3/8/13 by the Social Service Consultant. The nurse staff was re-education Psychotropic medication use by March 24, 2013 by Social Services.	ation
				Before any resident receives new order for a psychoactive drug the second control of the second control o	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED				
		155152	A. BUILDING B. WING	00	02/22/2013		
	COVIDER OR SUPPLIER	VING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
	SUMMARY S' (EACH DEFICIEN		STREET	MAIN ST CELLO, IN 47960 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE	TION (X5) COMPLETION DATE THE PROPRIATE COMPLETION DATE The property of the edication. The end of the property of the edication. The end of the edication. The edication of the edication. The end of the edication. The edication of the edication		
				needed, to ensure reside are met. The Charge Nurse responsible to follow-up of consultation orders as ne	is on		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED	
		155152	B. WING	02/22/2013	
	PROVIDER OR SUPPLIEF	IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODI I MAIN ST ICELLO, IN 47960	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	The Interdisciplinary Tereviews Physician Orders and Hour Report, to ensure pertiner are referred to the appropriate departments. The orders from weekend are reviewed on the rebusiness day. The manager or notified by the charge nurse of information on the weekends a holidays, as needed. The Social Service or designee will ensure implementation or compliant March 25, 2013. Non-compliance wiff facility policy and proceduresult in employee re-eduand/or disciplinary action. How the corrective action will be monitored to ensure deficient practice will not i.e., what quality assurar program will be put into The CQI tools titled "Psychoactive Management" weekly times four, me times three and quarterly thereafter for at least six me to ensure compliance with practices. The CQI committee reviews the audits monthly	the 24 Into orders the next In duty is pertinent Ind Director Ince by Ince Ince Ince Ince Ince Ince Ince Inc

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155152	A. BUILDING B. WING		02/22/2013
	PROVIDER OR SUPPLIE	R LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				action plans are developed as threshold of 95% is not met to ensure continual compliance.	
				The Director of Nursing Services and the Social Service Director or their designee is responsible to monitor for compliance.	
				Compliance Date: March 24 2013	,
	reviewed on 2/ The Significan Data Set (MDS 1/16/13, indica Brief Interview (BIMS) score of cognitive impal indicated the repsychiatric dial depression, are (other than schild A Physician's of indicated the real Ativan (an anti	order dated 11/12/12, esident was to receive -anxiety medication)			
	A Physician's of indicated the reservoir Seroquel (an a	on an as-needed basis. order dated 11/21/12, esident was to receive			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155152	B. WIN	G		02/22/2013
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
MONITIO	ELLO 40010TED L	NAME AND LIE ALTHOUGH			MAIN ST	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTIO	CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG				TAG		DATE
	mg in the morn	mig.				
	Interview with t	the Social Services				
		2/13 at 8:55 a.m.,				
		tivan was used to treat				
		e Seroquel was an				
	anti-depressan	•				
	and dopicosan	it modioation.				
	Resident #65's	February 2013				
	Medication Administration Record (MAR) listed diagnoses, which included, but were not limited to,					
	· ·	arkinson's, Depression,				
		sorder, Worsening of				
	Alzheimer's, Be	•				
	Delusions, Inso					
	•	,				
	Further intervie	ew with the Social				
	Service Directo	or indicated the facility				
	had just began	a new system in the				
	past month in r	reassessing for the				
	need of medica	ations as behavioral				
	interventions.	The Social Service				
		nted Behavior Flow				
	sheets and ind	icated monthly review				
	meetings were	starting, but there was				
		at there had been				
	ongoing reassessment of the					
	resident's use	of psychoactive				
	medications.					
		n on 2/18/13 at 12:20				
		e lunch meal, staff				
		get Resident #61 to				
	open his eyes	while sitting at the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILI		NSTRUCTION 00	(X3) DATE : COMPL		
		155152	B. WING			02/22/	2013
	PROVIDER OR SUPPLIED	IVING AND HEALTHCARE		1120 N	.DDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observed sitting in the late more other residents activities. Observed sitting in the late more other residents activities. Observed sitting in a characteristing in a characteri	g with his eyes closed ning prior to lunch while were involved in servations on 2/19 at 2/20/13 at 2:45 p.m., dent in the dayroom ir with his eyes closed. ident #61's record on 59 a.m., indicated a mum Data Set (MDS) ated 11/13/12. The the resident had the alzheimer's dementia, bychotic disorder other renia. The staff mood section, esident had trouble or sleeping too much. February 2013 ministration Record ed the resident's luded but were not eimer's with tremors, chronic constipation, insomnia, dementia and depression. The dithe resident was tonin (an herbal resleep) 5 milligrams edtime. Interview with vice Director on 2/22/13 adicated the Melatonin					

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Facility ID: 000072

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155152	B. WIN	G		02/22/	2013
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON BOTTEIEN				MAIN ST		
MONTIC	ELLO ASSISTED LI	IVING AND HEALTHCARE		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was used to tre	eat insomnia.					
	1/31/13, indicatinterventions for management, rencourage residay. Further interviews Service Director had just began past month in reneed of medicates and review meeting there was no estimated been ongoing resident "had nor this month." Director indicate physician had yeassess the remedication.	care plan updated on ted the following or Insomnia; pain reposition, and dent to be awake in with the Social or, indicated the facility a new system in the reassessing for the ations. The Social or presented Behavior and indicated monthly as were starting, but vidence there had reassessment of the of Melatonin. The Director indicated the roi insomnia last month The Social Service red no meeting with the resident's need for the resident's need for the resident #131 was 22/13 at 3:27 p.m. The					
	depression" wit	as diagnosed with "mild th no behaviors and rief Interview for					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155152	B. WIN			02/22/	2013
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1120 N	MAIN ST		
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	score of 13/15,					
	_	as cognitively intact.					
	Review of the I	•					
		ers summary (POS),					
	_	noses including, but not					
	· ·	onic Obstructive					
	•	ease, Ataxia, Bladder					
	•	ntia, Altered Mental					
		ute renal Failure,					
		entia with Delusions,					
	•	incephalopathy and					
		POS indicated the					
	•	rescribed Trazadone					
		ssant) 50 milligrams					
	(mg) 1 hour be						
	•	nedication to treat					
	•	mg twice daily,					
	Diazepam (an	•					
	· · · · · · · · · · · · · · · · · · ·	mg twice daily, and					
	,	antidepressant					
	,	mg in the morning and					
	10 mg in the ev	vening.					
	A 2/15/13 Phvs	sician's progress note,					
	,	esident had also been					
	receiving Rem						
	anti-depressan	•					
	•	ecause the resident					
		feels too sedated					
	(since starting						
		resident's 1/22/13 Care					
	,	the resident was					
		2/18/12. The resident's					
	Care Plan inclu	uded interventions for					

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Facility ID: 000072

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUILDING	00	COMPLETED
		100102	B. WING		02/22/2013
NAME OF P	ROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	FILO ASSISTED I	IVING AND HEALTHCARE		N MAIN ST ICELLO, IN 47960	
				T	07.5
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		of delusions of money			
		al aggression to staff"			
		iated on 1/8/13.			
	However, the	lanuary 2013 and			
		Behavior Tracking			
	Flow Sheets, i	•			
	behaviors had	not been exhibited			
	since the care	plan was initiated.			
	There was no	ndication in the			
		rd indicating an			
		ad been completed to			
	determine a ne	ed for the medications.			
		the Social Service			
		2/13 at 8:55 a.m.,			
		would need to find out			
	•	nt was on medications			
	used to treat d	epression.			
	3.1-31(a)				
	3.1-31(a)				

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Event ID: 2XHN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155152	B. WING	3		02/22/	2013
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE		1120 N	NDDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	483.20(g) - (j) ASSESSMENT ACCURACY/COO The assessment resident's status. A registered nurs coordinate each a appropriate partic professionals. A registered nurs the assessment is Each individual with assessment in accuracy of that pure the accuracy of that pure the accuracy of the professional is assessment; or a and knowingly call certify a material resident assessment.	DRDINATION/CERTIFIED must accurately reflect the e must conduct or assessment with the cipation of health			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	
	each assessment Clinical disagreer material and false	nent does not constitute a e statement.					
	review, the faci assess a reside of 3 residents r	view and record lity failed to accurately ent's dental status for 1 eviewed for dental	F02°	78	F278 Assessment Accuracy/Coordination/Certified		03/24/2013
		7 who met the criteria ces. (Resident #76)			It is the practice of this provide accurately assess residents' dental status on the MDS.	er to	

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Event ID: 2XHN11

Facility ID: 000072

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI			ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	TED
		155152	A. BUII B. WIN			02/22/2	013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			MAIN ST		
MONTIC	FILO ASSISTED I	IVING AND HEALTHCARE			CELLO, IN 47960		
					02220; 114 47 000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 2/19/13 at 1 resident was n soaked on a ro				What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice?		
	review indicate diagnoses, incl limited to, arthrosteoporosis, of depression. R	8:44 a.m., record and Resident #76's luded, but were not ritis, hypertension, dementia, and eview of the Initial MDS a Set) assessment			Resident #76's MDS has be modified to reflect her dental status.	en	
	dated 10/25/12	2, indicated the resident as having all her			How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take		
	11:12 a.m., ind of the resident' LPN located th note dated 10/	LPN #4 on 2/22/13 at licated she was unsure s dental status. The e resident's Admission 19/12, which indicated dupper and lower			All residents have the potent to be affected by the alleged deficier practice. All residents' MDSs were reviewed to ensure their correct den status was reflected.	nt	
	on 2/22/13 at 1 resident did ha dentures. The indicated the reincorrectly asset	the MDS Coordinator :36 p.m., indicated the ve upper and lower MDS Coordinator esident had been essed as having her n her Initial MDS			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	ito	
	3.1-31(c)(9)				Dental status is reviewed or	n all	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING		COMPLETED 02/22/2013	
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE I MAIN ST ICELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) admission, comprehensive, and	(X5) COMPLETION DATE	
				significant change MDSs. The MDS coordinator and assistant received re-education on reviewing dental status on the MDS the Executive Director by March 24, 2013. Non-compliance with facility policy and procedure marked result in employee re-education and/or disciplinary action.	nay	
				How the corrective action(s) will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place	eur,	
				The CQI tool "Assessments (Admission, Quarterly, Significant Change) will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with obtaining and documenting radiology results	e I	
				The CQI committee reviews the audits monthly an action plans are developed as threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may resin employee re-education or	the	

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PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00	COMPLETED
155152	B. WING	02/22/2013
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCAR	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960	3
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATI	N) TAG CROSS-REFERENCED TO THE APPRI	OPRIATE (X5) COMPLETION DATE
RESOLUTION ON ESCUEDENTIFICING INFORMATI	disciplinary action. The Director of Nurservices or her designeed responsible to monitor for compliance. Compliance Date: 24, 2013	sing is

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155152	B. WIN			02/22/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
MONTICE		IVING AND HEALTHCARE			CELLO, IN 47960		
WONTICE	LLC AGGIGTED LI	WING AND FIEAETHOAKE		WONT	CLLC, IN 47 900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.20						
SS=D		PREHENSIVE CARE					
	PLANS						
		e the results of the					
		evelop, review and revise					
	the resident's con	nprehensive plan of care.					
	The facility must (develop a comprehensive					
		resident that includes					
		ctives and timetables to					
		medical, nursing, and					
	mental and psych	osocial needs that are					
	identified in the co	omprehensive assessment.					
	•	st describe the services					
		nished to attain or maintain					
		nest practicable physical,					
		hosocial well-being as					
		183.25; and any services vise be required under					
		not provided due to the					
	-	e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
	Based on obse	rvation, record review,	F02	79			03/24/2013
		the facility failed to			F279 Comprehensive Care Plans		
	ensure a care	-					
		s initiated for 2 of 10			It is the practice of this provider to		
	•				ensure that a care plan related to depression is initiated when a		
		wed for unnecessary			resident has that diagnosis.		
	,	Residents #65 and					
	#131)						
	Findings includ	e:					
					110000000000000000000000000000000000000		
	1. The record f	for Resident #65 was			What corrective action(s) will	I	
		20/13 at 10:51 a.m.			be accomplished for those		
		change Minimum			residents found to have been	ı	
	•	_			affected by the deficient		
	•	s) assessment dated			practice?		
	1/16/13, indicat	ted the resident had a					

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Event ID: 2XHN11

Facility ID: 000072

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155152	B. WIN			02/22/	2013
		_	, 11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	₹			MAIN ST		
	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		of Mental Status					
		of 3/15, indicating					
		irment. The MDS also					
		esident had the			· A comprehensive care	plan	
	psychiatric dia	gnoses of anxiety,			for Resident #65's has been		
	depression, ar	nd psychotic disorder			initiated related to her diagnos	sis	
	(other than sch	nizophrenia).			of depression.		
					Resident # 131 no long	er	
	A Physician's	order dated 11/12/12,			resides in our facility.	Ci	
	indicated the r	esident was to receive					
	Ativan (an anti	-anxiety medication)					
	0.5 milligrams	(mg) to be					
	_	on an as-needed basis.					
	A Physician's	order dated 11/21/12,			How will you identify other		
		esident was to receive			residents having the potential	al	
	Seroquel (an a				to be affected by the same		
	• •	mg at bedtime and 25			deficient practice and what		
	mg in the morr	•			corrective action will be take	n?	
		iiig.					
	Interview with	the Social Services					
	Director on 2/2	22/13 at 8:55 a.m.,			· Residents with a diagn	osis	
		tivan was used to treat			of depression have the potent	ial	
	anxiety and the	e Seroquel was an			to be affected by the alleged		
	anti-depressar	•			deficient practice.		
					Social Services will revi	ew	
	Review of the	resident's 1/21/13 Care			all residents with a diagnosis	_	
		I there were no			depression to ensure they have		
		or symptoms of			an appropriate corresponding		
	depression.				comprehensive care plan.		
	acpicasion.				. Copial Consises and the		
	Further intend	ew with the Social			Social Services and the Interdisciplinary team will review		
					psychoactive medication use within		
		or, indicated, "We do			first 5 days of admission to determin	ne	
	_	for depression. We do			past and present behaviors/moods exhibited, and appropriate diagnosis	8	
		r it. We look in Nurses'			and indication for use.		
	I notes and wat	ch for new and			I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155152	B. WING			02/22/	2013
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R.		l	MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	reviewed on 2/Minimum Data assessment dathe resident wadepression" with had a BIMS (Bound and	for Resident #131 was 22/13 at 3:27 p.m. The Set (MDS) ated 12/18/12, indicated as diagnosed with "mild th no behaviors and rief Interview for score of 13/15, was cognitively intact. February 2013 rs summary (POS), noses including, but not onic Obstructive ease, Ataxia, Bladder intia, Altered Mental ute renal Failure, entia with Delusions, incephalopathy and POS indicated the rescribed Trazadone is sant) 50 milligrams fore bedtime and antidepressant in mg in the morning and			resident's PHQ9 score, psychoactive medication use and recent progress notes during the MDS assessment period. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Frida (excluding holidays). The resident's plan of care is revie and revised, as needed. Significant resident behaviors reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident neare met. The Charge Nurse is responsible to follow-up on consultation orders and the 2 Hour Report, to ensure pertinent ordere referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on dut notified by the charge nurse of pertinformation on the weekends and holidays, as needed.	e e e e e e e e e e e e e e e e e e e	
	indicated the re receiving Remanti-depressan discontinued b	•			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	nto	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152 A. BUILDING B. WING 00 COMPLETED 02/22/2013	
155152	
b. White	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1120 N MAIN ST	
MONTICELLO ASSISTED LIVING AND HEALTHCARE MONTICELLO, IN 47960	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID	(5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DA	ГЕ
(since starting Remeron)."	
Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for "the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. The resident's record did not contain a Care Plan for depression. Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated there was no care plan written for symptoms of depression and she indicated she would need to find out why the resident was on medications used to treat depression. 3.1-35(a) The Interdisciplinary Team was re-educated on the importance of having a comprehensive care plan related to depression on 3/8/13. Nurses received re-educated on the importance of having a comprehensive care plan related to depression for those residents with a diagnosis of depression by Social Services by March 24, 2013. Social Services will review all residents with a diagnosis of depression to ensure they have an appropriate corresponding comprehensive care plan. Social Services and the Interdisciplinary Team was re-educated on the importance of having a comprehensive care plan to all the plant of the president of the social Service shy March 24, 2013. Social Services will review an appropriate corresponding comprehensive care plan. Social Services will review each residents with a diagnosis of depression to ensure they have an appropriate corresponding comprehensive care plan. Social Services will review each residents PHO9 score, psychoactive medication use and recent progress notes during the MDS assessment period. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The residents plan of care is reviewed	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THE TEAM	or conduction	155152	A. BUILDING		02/22/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	ROVIDER OR SUPPLIER	2		I MAIN ST	
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE		ICELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				and revised, as needed. Significant resident behaviors	s are
				reported to the nurse	
				manager-on-call on the	
				weekends and holidays, as needed, to ensure resident n	eeds
				are met.	
				· The Charge Nurse is	
				responsible to follow-up on	
				consultation orders as neede	ea.
				The Interdisciplinary Team	
				reviews Physician Orders and the a Hour Report, to ensure pertinent of	
				are referred to the appropriate departments. The orders from the	
				weekend are reviewed on the next	l l
				business day. The manager on du	•
				notified by the charge nurse of per information on the weekends and	unent
				holidays, as needed.	
				· Non-compliance with	
				facility policy and procedure	
				result in employee re-educate and/or disciplinary action.	ion
				and/or disciplinary action.	
				How the corrective action(s	s)
				will be monitored to ensure	
				deficient practice will not re i.e., what quality assurance	l l
				program will be put into pla	
				 The CQI tool titled "SS Care Plan" will be utilized by 	
				Interdisciplinary team weekly	
				times four, monthly times three	ee
				and quarterly thereafter for a	t

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THE TEAM	o. conduction	155152	A. BUILDING		02/22/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	2		MAIN ST	
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE		CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	least six months to ensure	DATE
				compliance with assessmen	t and
				documentation procedures.	
				· The CQI committee	
				reviews the audits monthly a	
				action plans are developed threshold of 95% is not met	
				ensure continual compliance	
				Non-compliance with facility	
				policy and procedure may re in employee re-education ar	
				disciplinary action.	IG/OI
				 The Director of Nursing Services and the Social Services 	_
				Director or their designee is	
				responsible to monitor for	
				compliance.	
				Compliance Date: March 2	4,
				2013	
			1		

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Facility ID: 000072

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MU A. BUII B. WIN	DING	onstruction 00	(X3) DATE S COMPL 02/22 /	ETED	
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE		1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0312 SS=D	483.25(a)(3) ADL CARE PROVERSIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene.	unable to carry out living receives the es to maintain good g, and personal and oral view and record	F03	12			03/24/2013
	oral care was p basis for 1 of 3 activities of dai residents who	lity failed to ensure provided on a regular residents reviewed for ly living of the 7 met the criteria for ly living. (Resident #			F 312 ADL Care provided for Dependent Residents It is the practice of this provider to ensure that oral care is provided for those residents needing assistance) .	
	on 2/19/13 at 1	Resident #76's family :04 p.m., indicated the ot getting her dentures			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		
	for Resident #7				Resident #76's dentures are cleaned on a regular basis as she wi allow. Her aide assignment sheet ar her health care plan have been updated.	II	
	Data Set (MDS 1/16/13, indicate	Quarterly Minimum b) assessment dated ted the resident was person assistance for ne.			How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be taken		

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AND PLAN (IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 IVING AND HEALTHCARE TATEMENT OF DEFICIENCIES	1120 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST CELLO, IN 47960 PROVIDER'S PLAN OF CORRECT	I (X5)
PREFIX TAG	Interview with 0 9:31 a.m., indicesident in denote the toothbrush her teeth as need indicated sheet had all of her inthe daily ADL (sheet used by denture care well throughout the resident refuse for an oral inspection of the daily ADL (sheet used by denture care well throughout the resident refuse for an oral inspection of the daily ADL (sheet used by denture care well throughout the resident refuse for an oral inspection of the daily and inspect	e day on 2/22/13, the dot open her mouth section. 11:12 a.m., interview adicated the resident's e dated 10/19/12, esident had upper and	PREFIX TAG	Residents requiring as with oral care have the potential affected by the deficient praction. All aide assignment shaudited to ensure they have the dental information. They will reviewed and updated as need. The DNS or her design conduct daily rounds to ensure assignment sheets are being for regarding dental care. Health care plans have updated for those residents the oral care. They will be reviewed quarterly basis and as needed. MDSs have been reviewed the correct dental information recorded. They will be reviewed quarterly basis and as needed. What measures will be gowen.	ESSISTANCE all to be ce. eets were e correct one ded. eets will e the aide ollowed e been at refuse ed on a . wed to mation is ed on a .	LETION TE
	verified the res and lower dent Coordinator ind had been incor having her natu	ident did have upper ures. The MDS dicated, the resident rectly assessed as ural teeth and did not an for dentures.		place or what systemic changes you will make the ensure that the deficient practice does not recur? Nursing staff will be responded by March 24, 2013 by the SDC/designee. The DNS or her design conduct daily rounds to ensure assignment sheets are being fregarding dental care.	ee will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 02/22/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION
			All aide assignment shee audited to ensure they have the dental information. They will be reviewed on a daily basis. Health care plans have bupdated for those residents that oral care. They will be reviewed quarterly basis and as needed. MDSs have been reviewensure the correct dental informate recorded. They will be reviewed quarterly basis and as needed. Non-compliance with facility policy and procedurate result in employee re-eduction and/or disciplinary action. How the corrective action will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into put int	ets were correct eeen refuse lon a ed to ation is lon a n e may ation (s) re the recur, ce blace?
			reviews the audits monthly	and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THE TENNY	or conduction	155152	A. BUILDING		02/22/2013
		-	B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8		MAIN ST	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION OPRIATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	action plans are developed	
				threshold of 95% is not me	
				ensure continual compliand	
				Non-compliance with facilit policy and procedure may	
				in employee re-education a	
				disciplinary action.	
				The Director of Nurs	sing
				Services or her designee is	
				responsible to monitor for compliance.	
				Compilance.	
				Compliance Date: March	n 24,
				2013	, l

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Facility ID: 000072

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
				T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			N MAIN ST	
MONTIC	ELLO ASSISTED LI	VING AND HEALTHCARE		TICELLO, IN 47960	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329 SS=E	from unnecessary drug is any drug v dose (including do excessive duratio monitoring; or with	DRUGS rug regimen must be free rug regimen must be free rug drugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications			
	consequences wh should be reduce combinations of the	ne presence of adverse nich indicate the dose d or discontinued; or any ne reasons above.			
	resident, the facili residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use receive gradual dispensional interversidents.	rehensive assessment of a ty must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to indition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue			
			F0329	F329 Unnecessary Drugs	03/24/2013
	residents and t antifungal drug received an an affected 5 of 10 for unnecessar	nedications for 4 he continued use of an for 1 resident who tifungal drug. This residents reviewed y medication use. f, #61, #65, #130 and		It is the practice of this provider to ensure that there are adequate indications for the use of psychoactive medications.	
	#131)			What corrective action(s) will be accomplished for those residents found to have beer	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2013	
	PROVIDER OR SUPPLIE	IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ALSO DEPOTE BY FULL TO DEPOTE A TOND	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	Findings include	de:	TAG	affected by the deficient practice?	DATE
	Resident #87 of indicated the reperson, place a responded appropriate to answers. The record for reviewed on 2/2 and indicated to admitted in Juli including, but rewith behavioral with delusions anxiety. The prindicated the religional region indicated the religion i	25 milligrams (mg) in tisperdal 0.25 mg in the		The physician orders for residents #87, #61, #65, and #130 a being followed. Resident #131 no longer resin the facility. The consultant pharmacist reviewed Residents #87, #61, #65, #130 medications to ensure that the are free from unnecessary drugs, making recommendations as needed. Residents #87, #61, #65, ar #130 medication regimens are reviewed routinely for a gradual dos reduction as required per state regulation. How will you identify other residents having the potentit to be affected by the same deficient practice and what corrective action will be taken	and ney ed. ad
	(MDS) assessindicated a Bri Status (BIMS) minimal cognit indicated the re behavior or moreceived antips	m Minimum Data Set ment, dated 8/1/12, ef Interview for Mental of 13/15, indicating ive deficit. The MDS esident had no bood problems and sychotic drugs and an t seven days a week.		Residents receiving psychoactive medication have the potential to be affected by the allegedeficient practice. Before any resident received new order for a psychoactive drug the will be thoroughly assessed by the physician for the use of the medicate.	s a hey

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155152	A. BUII B. WIN			02/22/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			MAIN ST		
MONTIC		IVING AND HEALTHCARE			CELLO, IN 47960		
WONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		WONT	CELEO, IN 47 900		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The 10/27/12 a MDS assessm of 15/15 (no co behavioral or n resident contin antipsychotic of week and an a days a week. Interview with t Director (SSD) p.m., indicated admitted to the husband was a was receiving t indicated it was SSD indicated non-pharmaco were to encour resident's husb short stays. Th facility used m monitor the res Review of the re Review of the re December 201 February 2013 had one incide December 201 Record review no clinical control	and 1/18/13, Quarterly ents, indicated a BIMS ognitive deficit) and no mood problems. The ued to receive drugs seven days a intidepressant seven the Social Service on 2/20/13 at 2:27 when the resident was a facility, the resident the drugs and he is due to delusions. The the logical interventions rage activities and the pand took her out for the SSD reported the conthly flow sheets to sident's behaviors. Information of the problem of the pand took her out for the SSD reported the conthly flow sheets to sident's behaviors. Information of the resident that of verbal distress in 2. Indicated there were traindications listed as choactive drugs could			Social Services and the Interdisciplinary team will review psychoactive medication use within first 5 days of admission to determin past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. A comprehensive care pland be created for assessment and track of the medication. Social Services will audit the Gradual Dose Reduction tracker on routine basis. Social Services will review or plans for residents using psychoactimedication for continued indication fuse and placement. A consultant pharmacist reviewach resident's medication regimen routinely but no less than monthly to ensure that they are free from unnecessary drugs, making recommendations as needed. Residents receiving psychoactive medication are reviewed routinely for a gradu dose reduction as required pestate regulation. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Frida (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors reported to the nurse	will king are ve for ews	
	to why the psy	choactive drugs could			and revised, as needed. Significant resident behaviors		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLET	ΓED
		155152	B. WIN			02/22/20	013
			В. WП		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEI	₹			MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 2/22/13 at	11:00 a.m., the			weekends and holidays, as	.	
	Executive Dire	ctor was informed of			needed, to ensure resident ne	eds	
	the concerns r	egarding the continued			are met.		
	use of the psyc	choactive drugs and			· The Charge Nurse is		
		additional information			responsible to follow-up on		
		indicated the resident			consultation orders as needed	l.	
		n by the psychological					
		ad seen before			The Interdisciplinary Team	,	
		ne facility. A request			reviews Physician Orders and the 24 Hour Report, to ensure pertinent ord		
		ne progress notes.			are referred to the appropriate		
	1740 111440 01 11	io progresso rioles.			departments. The orders from the weekend are reviewed on the next		
	On 2/22/12 at	11:30 a.m., the Director			business day. The manager on duty	/ is	
					notified by the charge nurse of pertir		
	_	s informed of the lack of			information on the weekends and		
	l -	garding the continued			holidays, as needed.		
		choactive drugs and					
		additional information					
	available.						
	On 2/22/13 at	1:30 p.m., the SSD			What measures will be put in	ito	
		vior flow sheets which			place or what systemic		
	•	d Section D of the MDS			changes you will make to		
					ensure that the deficient		
		other information was			practice does not recur?		
	⁻	licate the resident was					
		psychological services					
	1	gs were reviewed for			· Staff has been		
	continued need	d.			re-inserviced on completing th	e l	
					new/worsening behavior even		
					prior to PRN psychoactive		
					medication use or a new order	r for	
					psychoactive medication by		
					Social Services by March 24, 2013.		
					2010.		
					Social Services and the	e	
					Interdisciplinary Team will		
					conduct chart reviews of those	•	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155152	B. WIN	G		02/22/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					MAIN ST	
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	residents prescribed psychoac	DATE
					medication to determine the	LIVE
					appropriateness of use and	
					interventions.	
					· Within the first 5 days of	
ı					admission Social Services will	•
					review a resident's psychoacti	
					medication use to determine p	ast
					and present behaviors/moods exhibited and appropriate	
					diagnosis and indication for us	e.
					-	
					A comprehensive care p	
					will be created for assessment and tracking of the medication	
					and tracking of the medication	
					· Social Service is	
					responsible to review resident	
					behaviors with the Interdisciplinary Team at the	
					clinical meeting Monday-Frida	y
					(excluding holidays). The	
					resident's plan of care is review	wed
					and revised, as needed. Significant resident behaviors	are
					reported to the nurse	ui o
					manager-on-call on the	
					weekends and holidays, as	
					needed, to ensure resident neare met.	eas
					are met.	
					· The Charge Nurse is	
					responsible to follow-up on	
					consultation orders as needed	•
					· The Interdisciplinary Team	
					reviews Physician Orders and the 24	
					Hour Report, to ensure pertinent ord are referred to the appropriate	ers
ı					departments. The orders from the	
					weekend are reviewed on the next	, io
					business day. The manager on duty	7 15

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PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING 02/22/2013		
		IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
				notified by the charge nurse of prinformation on the weekends and holidays, as needed. Non-compliance with facility policy and procedure.	1
				result in employee re-educa and/or disciplinary action.	-
				How the corrective action will be monitored to ensur deficient practice will not i.e., what quality assurance program will be put into p	re the recur,
				The CQI tool "Psychoactive Management be utilized by the Interdiscipteam weekly times four, motimes three and quarterly thereafter for at least six moto ensure compliance with assessment and document procedures.	olinary onthly onths
				The CQI committee reviews the audits monthly action plans are developed threshold of 95% is not met ensure continual compliance Non-compliance with facility policy and procedure may rin employee re-education a disciplinary action.	as the to ee.
				· The Director of Nursi	ing

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Event ID: 2XHN11

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/22/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			Services or her designee is responsible to monitor for compliance.	
			Compliance Date: March 24, 2013	,
	2. The record for Resident #130 was reviewed on 2/21/13 at 10:29 a.m.			
	A Physician's order dated 12/18/12, indicated the resident was to receive an antifungal cream to excoriated areas below her bilateral breasts every shift until healed.			
	Review of the December 2012 Medication Administration Record (MAR), indicated the cream had been signed out every shift from 12/19-12/31/13.			
	Review of the January 2013 MAR, indicated the cream had been signed out every shift for the entire month.			
	The February 2013 MAR, indicated the cream had been signed out every shift from 2/1-2/21/13.			
	Review of the Weekly Skin Assessments dated 2/12/13, 2/5/13, 1/28/13, 1/21/13, 1/8/13 and 1/1/13, indicated the resident had no skin			

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	OF CORRECTION IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	issues and there was no documentation related to excoriation underneath the resident's breasts.			
	Interview with the resident on 2/21/13 at 3:35 p.m., indicated the cream underneath her breasts was still being applied by staff.			
	Interview with the BCD Unit manager on 2/22/13 at 9:10 a.m., indicated the resident's rash was gone and that she should no longer be receiving the anti-fungal cream.			
	3. The record for Resident #65 was reviewed on 2/20/13 at 10:51 a.m. A Physician's order dated 11/12/12, indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered on an as-needed basis. A Physician's order dated 11/21/12, indicated the resident was to receive Seroquel (an anti-psychotic medication) 50 mg at bedtime and 25 mg in the morning.			
	Interview with the Social Services Director on 2/22/13 at 8:55 a.m., indicated the Ativan was used to treat anxiety and the Seroquel was an anti-depressant medication.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155152	B. WIN	IG		02/22/	2013
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	FROVIDER OR SUFFEIL	R		1120 N	MAIN ST		
MONTIC	ELLO ASSISTED I	LIVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s February 2013					
		Iministration Record					
		liagnoses, which					
		were not limited to,					
		arkinson's, Depression,					
	1	sorder, Worsening of					
	Alzheimer's, E						
		omnia, anxiety. Review					
		t's 1/21/13 Care Plan,					
	indicated there	e were no interventions					
		of depression. Review					
	of the Decemb	per 2012, January and					
	February 2013	3 Medication					
	Administration	Records, indicated					
	Ativan was no	t needed as an					
	intervention in	over 60 days. The					
	record did not	indicate the continued					
	use of the med	dication was justified.					
	_ ,, ., .						
		ew with the Social					
		or, indicated the facility					
		n a new system in the					
		reassessing for the					
		ations as behavioral					
		The Social Service					
		nted Behavior Flow					
		dicated monthly review					
		e starting, but there was					
		nere had been ongoing					
		of the resident's use of					
	psychoactive						
	1	e Social Service					
		ated, "We do not do					
	1	pression. We do Care					
	Plan for it. We	look in Nurses' notes					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	ETED
		155152	B. WIN	NG		02/22/	2013
NAME OF I	PROVIDER OR SUPPLIE	TD.		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFEIL			1120 N	MAIN ST		
MONTIC	ELLO ASSISTED	LIVING AND HEALTHCARE		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		new and worsening					
	behavior."						
		0/40/40 4 40 00					
		n on 2/18/13 at 12:20					
		ne lunch meal, staff					
		o get Resident #61 to					
		while sitting at the					
		he resident had been					
		ng with his eyes closed					
		rning prior to lunch while					
		s were involved in					
		servations on 2/19 at					
		d 2/20/13 at 2:45 p.m.,					
		dent in the dayroom					
	sitting in a cha	air with his eyes closed.					
	Dovious of Dos	aident #61's Fabruary					
		sident #61's February ion Administration					
) on 2/20/13 at 10:59					
	•	d the resident's					
	· ·	cluded but were not					
	_	neimer's with tremors,					
	· ·	chronic constipation,					
	1 * .	insomnia, dementia					
	,	and depression. The					
	1	ed the resident was					
	· ·	atonin (an herbal					
	_	or sleep) 5 milligrams					
		pedtime. Interview with					
	1 \ 0,	vice Director on 2/22/13					
		ndicated the Melatonin					
	was used to tr						
	was used to the	tal IIISUIIIIIIa.					
	The resident's	care plan updated on					
		ated the following					
	1/3 1/ 13, IIIUlCa	ated the following					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2013
	PROVIDER OR SUPPLIE	R LIVING AND HEALTHCARE	STREET . 1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	management,	or Insomnia; pain reposition, and ident to be awake in			
	Service Direct had just begar past month in need of medic Service Direct Flow sheets at review meeting there was no element on the service resident suse Social Service resident had nor this month." Director indicate physician had	ew with the Social or, indicated the facility in a new system in the reassessing for the ations. The Social or presented Behavior and indicated monthly gs were starting, but evidence there had reassessment of the of Melatonin. The Director indicated the no insomnia last month of The Social Service atted no meeting with the yet occurred to esident's need for the			
	reviewed on 2. Minimum Data assessment dathe resident with depression with ad a BIMS (E Mental Status) the February 2 summary (POS	for Resident #131 was /22/13 at 3:27 p.m. The a Set (MDS) ated 12/18/12, indicated as diagnosed with "mild ith no behaviors and Brief Interview for a score of 13. Review of 2013 Physician orders S), indicated diagnoses not limited to, Chronic			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2013
	PROVIDER OR SUPPLIE	L ≀ IVING AND HEALTHCARE	STREET 1120 N	ADDRESS, CITY, STATE, ZIP CODE I MAIN ST ICELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Ataxia, Bladde Altered Mental renal Failure, I Delusions, And Encephalopath POS indicated prescribed Trainti-depressar hour before be medication to twice daily, Diamedication) 5 Paroxetine (and medication) 20 10 mg in the e A 2/15/13 Phy indicated the receiving Remanti-depressar discontinued by "states that he (since starting) Review of the Plan, indicated admitted on 12 Care Plan incluming the behavior of taken and very which were initial However, the February 2013 Flow Sheets, in the properties of the plan incluming th	the resident was zadone (an at) 50 milligrams (mg) 1 edtime, Namenda (a treat Alzheimer's) 5 mg azepam (an anti-anxiety mg twice daily, and antidepressant o mg in the morning and vening. Sician's progress note, esident had also been eron (an at) but it was ecause the resident feels too sedated			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
NAME OF P	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
MONTIO	ELLO 40010TED I	NAME AND LIE ALTHOUGH		MAIN ST	
MONTICI		IVING AND HEALTHCARE	MONTI	CELLO, IN 47960	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE
		plan was initiated.			
		indication in the			
		ord indicating an			
		ad been completed to			
		eed for the medications.			
		sident's record did not			
		Plan for depression			
	-	n as to why the			
		sed to treat depression			
	were required.				
	. والمناسبة عند المسلمة	the Coeigl Comitee			
		the Social Service			
		22/13 at 8:55 a.m.,			
		e was no care plan			
	_	iptoms of depression			
		ted she would need to			
	_	e resident was on			
	medications us	sed to treat depression.			
	3.1-48(a)(4)				
	3.1-48(b)(2)				
	3. I-40(b)(2)				

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Event ID: 2XHN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155152		LDING		02/22/	2013
		100102	B. WIN	G		OZIZZI	2010
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	KO VIDEK OK SUFFLIEK	<u>.</u>		1120 N	MAIN ST		
MONTICE	ELLO ASSISTED LI	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0334	483.25(n)						
SS=C	• •	PNEUMOCOCCAL					
33-0	IMMUNIZATIONS						
		develop policies and					
	procedures that e						
	(i) Before offering						
		ch resident, or the					
		epresentative receives					
	•	ing the benefits and					
	•	ects of the immunization;					
	· ·	is offered an influenza					
		ober 1 through March 31					
	•	the immunization is					
		ndicated or the resident has					
	•	nunized during this time					
	period;						
		or the resident's legal					
		s the opportunity to refuse					
	immunization; and						
	(iv) The resident's	s medical record includes					
	documentation th	at indicates, at a minimum,					
	the following:						
	(A) That the resi	dent or resident's legal					
	representative wa	as provided education					
	regarding the ben	nefits and potential side					
	effects of influenz	a immunization; and					
		dent either received the					
	influenza immuniz	zation or did not receive the					
	influenza immuniz	zation due to medical					
	contraindications	or refusal.					
	The facility must of	develop policies and					
	procedures that e						
	•	the pneumococcal					
		ch resident, or the					
		epresentative receives					
		ing the benefits and					
	•	ects of the immunization;					
	•	is offered a pneumococcal					
	· ·	less the immunization is					
		ndicated or the resident has					
	already been imm						
	aneauy Deen IIIII	iui iizgu,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 02/22/2013	
		155152	B. WING		02/22/2013
	PROVIDER OR SUPPLIER	IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR (iii) The resident of representative has immunization; and (iv) The resident's documentation that the following: (A) That the result regarding the bereffects of pneumon (B) That the result of medical contractive of the pneumon of th	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) or the resident's legal as the opportunity to refuse d s medical record includes nat indicated, at a minimum, ident or resident's legal as provided education nefits and potential side ococcal immunization; and ident either received the nunnization or did not mococcal immunization due indication or refusal. ive, based on an practitioner a second pneumococcal by be given after 5 years pneumococcal less medically refuses the ation. rd review and acility failed to ensure elated to risks and annual influenza rovided to 5 of 5 wed for influenza and	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY) F334 Influenza and Pneumococcal Immunizations It is the practice of this provider to ensure that writt notice related to risks and benefits of an annual influence.	03/24/2013
	#7, #16, #28, #	·		vaccine is provided to all residents.	
	Findings included During the Infe	ction control		What corrective action(s) will be accomplished for those	ш
	indicated Residues #28, #68, and	n 2/22/13 at 2:00 p.m., dents #7, #16, #138 had not received e of the risks and		residents found to have been affected by the deficient practice?	n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
			_	EET ADDRESS, CITY, STATE, ZIP CODE	L
NAME OF P	ROVIDER OR SUPPLIE	CR.		0 N MAIN ST	
MONTIC	ELLO ASSISTED I	LIVING AND HEALTHCARE		NTICELLO, IN 47960	
MONTIC	ELLO ASSISTED	EIVING AND HEALTHCARE	IVIOI	MIICELEO, IN 47900	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	benefits of rec	ceiving the influenza			
	vaccination.				
				Residents #7, #16, #28,	
	Interview with	the Staff development		and #138 have all received written notice related to risks and benefit	
		n 2/22/13 at 3:15 p.m.,		annual influenza vaccine is provi	
		vritten information was		all residents.	
		elated to the flu vaccine,			
	just verbal info	ormation.		How will you identify attach	_
				How will you identify othe residents having the pote	
	3.1-13(a)			to be affected by the same	
				deficient practice and wha	
				corrective action will be to	
				corrective action will be to	akeii:
				· All residents have the po	tential
				to be affected by the alleged def	icient
				practice.	
				· An audit was conducted	of
				resident records to ensure that re	
				who declined the flu vaccination	
				received written notice related to	
				risks and benefits of an annual fl vaccination.	u
				vacomation.	
				At admission all residen	ts
				receive written notice related to	risks
				and benefits of an annual flu	
				vaccination.	
				· Written notice related to	the risks
				and benefits of an annual influer	
				vaccine will be given to residents	s on a
				yearly basis when consents are	
				updated.	
				What measures will be pu	t into
				place or what systemic	
Ī			I	1	ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
		155152	A. BUI B. WIN			02/22/2013
			B. WIN			
NAME OF PI	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE	
					MAIN ST	
MONTICE	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROUGEDIG N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		,			changes you will make to	
					ensure that the deficient	
					practice does not recur?	
					practice does not recui :	
					Written notice related to the	
					risks and benefits of an annual	
					influenza vaccine will be given to	
					residents on a yearly basis when	
					consents are updated.	
					AA - desirate to the state of	
				At admission all residents receive written notice related to risks	<u> </u>	
					and benefits of an annual flu	
					vaccination.	
					 The infection control nu 	rse
					was re-educated about the	
					importance of providing reside	ents
					with written notice related to the	ne
					risks and benefits of an annua	ıl
					influenza vaccine by March 24	l,
					2013 by the Executive Directo	r.
					The Infection Court	
					The Infection Control	iou
					Nurse or her designee will rev	
					all new admission records with	1111
					a week to ensure that they received written notice related	to
					the risks and benefits of an	10
					annual influenza vaccine.	
					amida imidenza vaccine.	
					Non-compliance with	
					facility policy and procedure m	nav
					result in employee re-education	
					and/or disciplinary action.	
					How the corrective action(s)	
					will be monitored to ensure t	he
					deficient practice will not rec	eur,

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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUILDING 00 CC		COMPLETED 02/22/2013
	ROVIDER OR SUPPLIER	I R IVING AND HEALTHCARE	STREET	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE) i.e., what quality assurance	BE COMPLETION DATE
				program will be put into p	lace?
				The CQI tool "Resid Immunizations" will be utilize the Interdisciplinary team we times four, monthly times the and quarterly thereafter for least six months to ensure compliance with obtaining a documenting radiology residence.	zed by veekly nree at
				The CQI committee reviews the audits monthly action plans are developed threshold of 95% is not merensure continual compliance. Non-compliance with facility policy and procedure may in employee re-education of disciplinary action.	as the t to ce. y result
				The Director of Nurs Services or her designee is responsible to monitor for compliance.	
				Compliance Date: 1 24, 2013	March

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155152	B. WIN			02/22/2013
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			1120 N	MAIN ST	
	ELLO ASSISTED L	VING AND HEALTHCARE		MONTI	CELLO, IN 47960	
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0428 SS=D	IRREGULAR, AC The drug regimer reviewed at least licensed pharmacist n irregularities to th the director of nui must be acted up Based on obse record review, ensure the pha	n of each resident must be once a month by a sist. nust report any e attending physician, and resing, and these reports	F04	28	F428 Drug Regimen Review, Repo Irregular, Act On	03/24/2013
	continued used drug for 1 of 10 unnecessary definition of the continued used from the continued used for the conti	of an antipsychotic) residents reviewed for rugs. (Resident #87) e: id interview of Resident at 2:00 p.m., indicated			It is the practice of this provide ensure that the pharmacist provides monthly reviews regarding the continued use of antipsychotic drugs.	f
	place and time responded app	ns alert to person, The resident ropriately to several provided good insight			What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice?	nts
	reviewed on 2/ and indicated t admitted in July including, but n				The pharmacist has reviewed Resident #87's antipsychotic drug us and made recommendations as needed. How will you identify other residents having the potential be affected by the same defici	to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X:			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	I DING	00	COMPLE	ETED
		155152	A. BUI. B. WIN	LDING IG		02/22/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MAIN ST		
MONTIC	ELLO VGGIGLEDI	IVING AND HEALTHCARE			CELLO, IN 47960		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		WONT	CELEO, IN 47 900		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ed Risperdal (an			practice and what corrective		
	anti-psychotic medication) 0.25				action will be taken?		
	milligrams (mg) in the morning and					
	0.25 mg in the evening.						
					Residents that receive an		
	The Admission Minimum Data Set				antipsychotic drug have the potentia	l to	
					be affected by the alleged deficient		
	(MDS) assessment, dated 8/1/12, indicated a Brief Interview for Mental Status (BIMS) of 13/15, indicating				practice.		
					The consultant pharmacist v	vill	
	, ,				review the drug regimen of each		
	minimal cognitive deficit. The MDS				resident receiving a psychoactive		
	indicated the resident had no				medication at least once a month.		
		ood problems and			The pharmacist will provide		
		sychotic drugs seven			monthly reviews regarding the		
	days a week.				continued use of antipsychotic		
					medication use for residents receiving psychoactive medication.	ng	
	The 10/27/12 a	and 1/18/13, Quarterly			psychoactive medication.		
	MDS assessm	ents, indicated a BIMS			Social Services will review t	he	
		ognitive deficit) and no			monthly pharmacist report to ensure	all	
	,	nood problems. The			residents receiving psychoactive		
	resident contin	•			medications have been reviewed.		
		lrugs seven days a					
		ilugs severi days a					
	week.				What measures will be put into		
					place or what systemic change		
		the Social Service			you will make to ensure that the		
	Director (SSD)	on 2/20/13 at 2:27			deficient practice does not rec	ur?	
	p.m., indicated	the facility used					
	monthly flow sl	neets to monitor the					
	resident's beha	aviors. Review of the			· The consultant pharmacist v	vill	
	monthly flow sl	heets for December			review the drug regimen of each		
	_	2013 and February			resident receiving a psychoactive medication at least once a month.		
		the resident had one			medication at least once a month.		
	incident of verb				The pharmacist will provide		
	December 201				monthly reviews regarding the		
		۷.			continued use of antipsychotic		
]				medication use for residents receiving psychoactive medication.	ng	
	Record review	indicated there was no	1		psychoactive medication.	l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
	SUMMARY	ER LIVING AND HEALTHCARE STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	STREET 1120 N	ADDRESS, CITY, STATE, ZIP CODE I MAIN ST ICELLO, IN 47960 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	clinical contrainment why the psychological contrainment was not any recommentation any recommentation of the antipsychological contrainmentation of the psychological contrainmentation of the p	indications listed as to noactive drugs could not indication there were indations regarding the ors requiring the use of otic drug. There were dations regarding the ipsychotic drug until the pharmacist ose reduction. 11:00 a.m., the vector was informed of regarding the continued or choactive drugs and or additional information of further pharmacist ions were provided at		Social Services will review the monthly pharmacist report to ensure residents receiving psychoactive medications have been reviewed. Non-compliance with facility policy and procedure mand/or disciplinary action. How the corrective action(s) was been monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The CQI tool "Unnecessary Medications" wis be utilized by the Interdisciplinate team weekly times four, month times three and quarterly thereafter for at least six month to ensure compliance with obtaining and documenting radiology results. The CQI committee reviews the audits monthly an action plans are developed as threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may resin employee re-education or disciplinary action. The Director of Nursing	ne all ary no li li ary niy hs

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				MAIN ST	
		IVING AND HEALTHCARE		CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				Services or her designee is responsible to monitor for	
				compliance.	
				Compliance Date: March 24	
				Compliance Date: March 24, 2013	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/22/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the nurses' station was equipped to receive a resident call light for 1 of 9 rooms on the 2 North unit. (Room #247) Findings include: On 2/18/13 at 2:15 p.m., the call light	F0463	F463 Resident Call System-Rooms/Toilet/Bath It is the practice of this provider to ensure that the nurses' station is equipped to receive resident call lights.	03/24/2013
	located next to Resident #135's bed in room #247, did not function when pressed. The call light did not illuminate at the nurses' station either. Interview with the Assistant Director of Nursing at this time, indicated the resident's call light was not working and she would notify maintenance.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The call light for Room #247 was repaired immediate.	
	Two residents resided in this room. 3.1-19(u)(1)		How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
NAME OF P	ROVIDER OR SUPPLIE	R	STREET.	ADDRESS, CITY, STATE, ZIP CODE	
				MAIN ST	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE	MONTI	CELLO, IN 47960	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
				potential to be affected by the alleged deficient practice.	
				aneged denotern practice.	
				· All call lights in the build	ling
				have been checked to ensure	
				they sound at the nurse's stati	on.
				Customer Service	
				Representatives were inservice	ed
				by March 24, 2013 related to	
				checking call light function	
				routinely with room rounds by Maintenance Supervisor.	tne
				Waintenance Supervisor.	
				· Call light function will be	e
				checked during the Customer	
				Service Representative room	
				checks to ensure they are sounding at the nurse's station	
				Sounding at the nurse's station	1.
				· Housekeeping staff wer	e
				inserviced by March 24, 2013	
				related to checking call light	
				function routinely by the Maintenance Supervisor.	
				Waintenance Supervisor.	
				· Housekeeping will chec	k
				the call lights on a routine bas	is to
				ensure they are sounding at the	ne
				nurse's station.	
				Maintenance will check	call
				light function according to the	
				preventative maintenance	
				schedule and as needed to	
				ensure they are sounding at the nurse's station.	ie
				nuises station.	
				What measures will be put in	ito
				place or what systemic	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN11

Facility ID: 000072

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155152	B. WING		02/22/2013
	PROVIDER OR SUPPLIE	R IVING AND HEALTHCARE	1120	ET ADDRESS, CITY, STATE, ZIP CODE N MAIN ST TICELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				changes you will make to ensure that the deficient practice does not recur?	
				Customer Service Representatives were inservi by March 24, 2013 related to checking call light function routinely with room rounds by Maintenance Supervisor.	
				Call light function will be checked during the Customer Service Representative room checks to ensure they are sounding at the nurse's station	
				 Housekeeping staff we inserviced by March 24, 2013 related to checking call light function routinely by the Maintenance Supervisor. 	
				 Housekeeping will cher the call lights on a routine basensure they are sounding at to nurse's station. 	sis to
				 Maintenance will check light function according to the preventative maintenance schedule and as needed to ensure they are sounding at t nurse's station. 	, "
				 Non-compliance with facility policy and procedure r result in employee re-education and/or disciplinary action. 	

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Event ID: 2XHN11

Facility ID: 000072

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155152	B. WING		02/22/2013
	PROVIDER OR SUPPLIE	R LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE I MAIN ST ICELLO, IN 47960	•
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROWINED'S DLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla	the cur,
				The CQI tool titled "We Tasks" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly for at least six months thereafter to ensure compliance with assessment documentation procedures. The CQI committee reviews the audits monthly at action plans are developed a threshold of 95% is not met the ensure continual compliance. Non-compliance with facility policy and procedure may resin employee re-education and disciplinary action. The Maintenance Supervisor or his designee is responsible to monitor for compliance. Compliance Date: March 2 2013	and and s the co

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUILDING 00 COMPLETE 02/22/201			(X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	02/22/2010
		VING AND HEALTHCARE			MAIN ST CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG				TAG	DEFICIENCY)	DATE
F0465 SS=C	483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must persidents, staff and Based on obsethe facility failed sanitary, and concenvironment for walls, doors, and paint, chipped lidisrepair, and a relation to a month of the potential to who reside in the potential to who reside in the Findings included During the Enverside 2/21/13 at 9:32 Maintenance Deside Housekeeping was observed: 1. C Hall: a. There was designed and the common toose outlet concoverhead light of floor trim in the sanitary and concentry door to Concentry the common toose outlet concoverhead light of floor trim in the sanitary and concentry door to Concentry door trim in the sanitary and concentry door to Concentry door door door door door door door do	JAL/SANITARY/COMFOR Incrovide a safe, functional, infortable environment for ad the public. Invation and interview, and to provide a safe, comfortable in residents, related to and trim with chipped in andrail, wallpaper in a hazard potential in otion sensor. This had affect all 92 residents are facility. The increase of loose in the heated and a piece of loose entryway. Fourteen	F04		F465 Environment It is the practice of this provider to ensure that the facility provides a safe, sanitary, and comfortable environment for residents. What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice? The entry door C hall has been painted. The loose outlet cover for the hear overhead light and the floor trin the entry way to shower are on C hall have been repaired. The exterior side of room #13 door was cleaned and repaint. The door frame to the bathr of room #125 has been repair and repainted. The door to room #128 was replaced and the will a was replaced and the wil	o3/24/2013 see n to ne ted im ea . 2's ted. to oom red The n all
	overhead light	and a piece of loose entryway. Fourteen			and repainted. The door to room #128 was repainted. caulk around the toilet in roon	The n all oor

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155152	B. WIN			02/22/2	2013
			Б. WII	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	8			MAIN ST		
MONTIC	ELLO VGGIGLED I	IVING AND HEALTHCARE			CELLO, IN 47960		
MONTIC	WONTOLLEO AGGIOTED EIVING AND TIEAETHOARE			WICHTI	CLLEO, IN 47 900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	c. The exterior	r side of room #132's			repainted. The entry door		
	door was scuff	ed and room #128's			frame to D hall has been		
	door had chipp	ed paint. The door			repainted. • The dresser in ro		
		athroom of room #125			#139 has been repaired and the light fixture in the bathroom has		
		nd marred. In room			been cleaned. • In room #143		
		k around the toilet was			1 North, the walls next to the		
	•				hand towel dispenser have be	_{en}	
		ne bathroom and the			repaired and the arms of the		
		ed. The closet door of			commode have been replaced	l. •	
		d chipped and marred			In room #149, the wall around	the	
	paint. One resi	dent resided in room			bathroom sink has been		
	#125, one resid	dent resided in room			repainted and the walls have		
	#128, and one	resident resided in			been cleaned. The overhead		
	room #132.				light above the bed has been		
	100111 11 1021				repaired. The motion sensor h	nas	
	2. D Hall:				been moved and the aide		
	2. D Hall.				assignment sheet updated to indicate proper placement.	The	
					chipped handrail at the corner		
		chipped paint along the			near the entrance of 1 West ha		
	door frame of	entry.			been repaired. · On 2 West,		
					divots in the entry floor linoleu		
	b. In room #13	39, the dresser drawers			have been repaired. The		
		d and marred. There			missing square of handrail nea	ar	
		ects in the light fixture			the exit on 2 West has been		
		n. One resident resided			replaced. The wall in the 2		
		ii. One resident resided			West dining room has been	_	
	in this room.				repaired and the floor has bee	n	
					repaired. · In room #269, the base board has been repaired		
	3. 1 North:				and the wall has been repainted		
					near the heating unit. The	~	
	a. Room #143	had areas of the walls			bedside stand has been repair	red.	
	next to hand to	wel dispenser that			The bathroom door in room		
		air and the arms of the			#262 has been cleaned, repair	red	
	· ·	e chipped. Two			and repainted. The privacy		
		ed in this room.			curtain has been cleaned. The	~	
	1621061112 16210	cu iii tiiis tuutti.			dresser has been repaired.		
					room #273, the bathroom wall		
		had chipped paint			and the edge of the entry door		
	around the sin	k in the bathroom and			the room have been repaired a	and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE		COMPLETED		
		155152	B. WIN			02/22/2013	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			MAIN ST		
MONITIC	ELLO ASSISTED I	IVING AND HEAT THOADE			CELLO, IN 47960		
MONTIC	MONTICELLO ASSISTED LIVING AND HEALTHCARE			WONT	CELEO, IN 47 900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	E	LETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			ATE
	scuff marks on	the walls. The			repainted. On 2 North, the		
	overhead light	above the bed did not			bathroom door in room #246 h	as	
	work. A motio	n sensor was observed			been repaired and repainted.		
	to be in the mid	ddle of the floor			The caulk around the toilet has		
		ed, dresser, and			been replaced. How will yo identify other residents havir		
		residents resided in			the potential to be affected b	_	
		residents resided in			the same deficient practice a		
	this room.				what corrective action will be		
					taken? · All residents have		
	4. 1 West:				the potential to be affected by	-	
					alleged deficient practice.		
	a. A chipped h	andrail was observed			Customer Service		
		near the entrance.			Representatives were inservic	ed	
					by March 24, 2013 related to		
	5. 2 West:				noting any needed repairs and		
	J. 2 WESI.				reporting them to the		
					Maintenance Supervisor.		
	1	oor had 3 divots in the			During Customer Service roon	۱	
	linoleum appro	eximately 2 inches by 1			rounds, the Customer Service Representative will note any		
	inch.				needed repairs and report the	n	
					to the Maintenance Supervisor		
	b. There was	a missing square of			Housekeeping staff were	·	
	handrail near t	• .			inserviced by March 24, 2013		
					related to noting any needed		
	C There was	a missing section of			repairs and reporting them to	the	
		•			Maintenance Supervisor. ·		
		e dining room and			During daily cleaning,		
		were observed in the			Housekeeping staff will note a		
		dining room entry.			needed repairs and report the		
	Twenty-four re	sidents resided on this			to the Maintenance Supervisor The Maintenance Supervisor		
	unit.				his designee will be responsib		
					to ensure that all repairs are	`	
	d. Room #269	had a base board			completed within a reasonable		
	loose and paint peeling near the				time frame. What measur		
		he bedside stand with			will be put into place or what		
	_	scratches and were			systemic changes you will		
					make to ensure that the		
		residents resided in this			deficient practice does not		
	room.				recur? · Customer Service		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		155152				02/22/2	.013
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Representatives were inservice	ed	
	c The hathrod	om door in Room #262			by March 24, 2013 related to		
					noting any needed repairs and	t l	
	•	ped and marred on			reporting them to the		
	both sides of the	ne bathroom door. The			Maintenance Supervisor. ·		
	privacy curtain	was stained and the 3			During Customer Service roor		
	drawer dresser	r was scratched. Two			rounds, the Customer Service		
		led in this room.			Representative will note any		
					needed repairs and report the		
	d Das: 4070	مر المراجع المحموناه المحاد			to the Maintenance Superviso	r. ·	
		had chipped paint on			Housekeeping staff were		
	the bathroom v	walls and peeling paint			inserviced by March 24, 2013		
	on the edge of	the door in the entry of			related to noting any needed		
	the room. Two	residents resided in			repairs and reporting them to	the	
	this room.				Maintenance Supervisor.		
	1110 100111.				During daily cleaning,		
	0.01. (1				Housekeeping staff will note a		
	6. 2 North:				needed repairs and report the		
					to the Maintenance Superviso		
	a. Room #246	had a scratched and			The Maintenance Supervisor		
	marred door in	side the bathroom.			his designee will be responsib	ie	
		the base of the toilet			to ensure that all repairs are completed within a reasonable	,	
					time frame. Non-compliance		
	was discolored	1.			with facility policy and procedu		
					may result in employee	110	
	3.1-19(f)				re-education and/or disciplinar	rv	
					action. How the corrective	,	
					action(s) will be monitored to	,	
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p		
					into place? • The CQI tools		
					titled "Quality Control		
					Inspection-Housekeeping and		
					Preventative Maintenance		
					Performed this Month" will be		
					utilized by the Interdisciplinary	,	
					team weekly times four, month		
					times three and quarterly	·	
					thereafter for at least six mont	hs	
					to ensure compliance with		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE PRIEST TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT AND ASSISTED LIVING AND HEALTHCARE D PRIEST TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT AND ASSISTED LIVING AND HEALTHCARE D REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT AND ASSISTED ASSISTED AND ASSISTED ASSISTED AND ASSISTED ASSISTED AND ASSISTED ASSISTED AND ASSI		OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUILDING	00	COMPLETED 02/22/2013		
MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) MONTICELLO, IN 47960 (X5) COMPLETION DATE Assessment and documentation procedures. • The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. • The Maintenance Supervisor or his designee is responsible to monitor for compliance. Compliance Date: March 24,	NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG TAG PREFIX TAG PREFIX	MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE					
procedures. · The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Maintenance Supervisor or his designee is responsible to monitor for compliance. Compliance Date: March 24,	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	assessment and documentate procedures. • The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may resign employee re-education and disciplinary action. • The Maintenance Supervisor or high designee is responsible to monitor for compliance. Compliance Date: March 24	tion S S S S S S S S S S S S S S S S S S S		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN11

Facility ID: 000072

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO		COMPL	COMPLETED	
		155152	B. WIN			02/22/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1120 N	MAIN ST		
MONTICI	ELLO ASSISTED LI	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0502	483.75(j)(1)						
SS=D	ADMINISTRATIC						
		provide or obtain laboratory the needs of its residents.					
		consible for the quality and					
	timeliness of the						
	Based on recor		F05	02			03/24/2013
		acility failed to ensure					
		ol tests were completed			F502 Administration		
		ents who had orders			It is the practice of this provide	er to	
		of the 10 who were			ensure that hemoccult stool te		
					are completed.		
	reviewed for ur	•					
	,	Residents #68 and					
	#139)				\A/last same ative action (a) will be		
					What corrective action(s) will be accomplished for those reside		
	Findings includ	e:			found to have been affected by		
					the deficient practice?	,	
	1. The record	for Resident #68 was			·		
	reviewed on 2/2	20/13 at 9:39 a.m. The					
	resident's diagr	nosis included, but was					
	not limited to, a	nemia.			 The hemoccult stool tests for residents #68and #139 were obtaine 		
					and sent to the lab for testing.	u	
	A Physician's c	order dated 2/4/13,					
	indicated the re	esident was to have a					
	hemoccult stoo	ol test (a test to check			How will you identify other		
		stool) times three.			residents having the potential	to	
		,			be affected by the same defici		
	Review of the h	powel movement			practice and what corrective		
		indicated the resident			action will be taken?		
	•	rements on 2/6 at 9:05					
		2 a.m., 2/13 at 7:54					
					All residents who receiv	A 2	
	p.m., and 2/18/ 	'13 at 11:16 a.m.			physician's order for a hemoco		
	Intende 20 4	ha Oarand fla 11. '			stool test have the potential to		
		he Second floor Unit			affected.		
	-	22/13 at 8:55 a.m.,					
	indicated the re	esident did have an			· An audit will be complet	ed	

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Event ID: 2XHN11

Facility ID: 000072

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ED	
		155152	B. WIN			02/22/20	13
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDER OR SUPPLIER			1120 N	MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	OMPLETION
TAG		<u> </u>		TAG	of resident orders to determine	; if	DATE
	order for hemoccult tests and two				any other hemoccult stool test		
		had been obtained on			have been ordered.		
		ndicated the stool					
		d have been obtained			· When a hemoccult stoo	l	
	in a more time	y manner.			test order is received it will be entered into hot charting until		
		r D :1 / "400			obtained.		
		for Resident #139 was					
		20/13 at 8:48 a.m. The			· Monthly at rewrite		
	·	noses included, but			verification the Unit Manager of	or	
		d to, malnutrition and			designee will audit for routine hemoccult stool test orders an	4	
	incontinence.				place into hot charting until	u	
					obtained.		
		order dated 2/14/13,					
		esident was to have a					
		ol sample (a test to					
		d in the stool) times					
		ident was also to have			What measures will be put into		
	a stool sample				place or what systemic change	es	
	· ·	/lori (h. pylori) (a	you will make to ensure that the				
	bacteria in the	stomach).			deficient practice does not rec	ur?	
	Review of the	bowel movement					
		I, indicated the resident			Nursing staff were re-educate	ed l	
		ovement on 2/17 at			by March 24, 2013 on the proper	- u	
		8 at 9:23 a.m. and			procedure for tracking hemoccult sto	ol	
		2/20/13 at 2:19 p.m.			tests by the SDC/designee.		
					· When a hemoccult stoo		
	Interview with	the Second floor Unit			test order is received it will be		
		22/13 at 8:53 a.m.,			entered into hot charting until		
		tool for hemmocult and			obtained.		
		ot been collected as			· Monthly at rewrite		
	ordered.				verification the Unit Manager of	or	
	3.45.54.				designee will audit for routine		
	3.1-49(a)				hemoccult stool test orders an	d	
					place into hot charting until		
	I		ı				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED 02/22/2013		
	,	155152					
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1		
	ROVIDER OR SUPPLIEF		1120 N MAIN ST				
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE	MONTI	CELLO, IN 47960			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION DATE		
1710	REGGE/110K1 OK	LESC IDENTIFY THAT IN ORMETTION	1710	obtained.	DATE		
				 Non-compliance with facility policy and procedure 	may		
				result in employee re-educat			
				and/or disciplinary action.			
				How the corrective action(s) be monitored to ensure the	will		
				deficient practice will not rec	ur,		
				i.e., what quality assurance	-0		
				program will be put into place	e?		
				· The CQI tool			
				"Labs/Diagnostics" will be ut	ilized		
				by the Interdisciplinary team			
				weekly times four, monthly ti three and quarterly thereafte			
				at least six months to ensure			
				compliance with assessment	t and		
				documentation procedures.			
				· The CQI committee			
				reviews the audits monthly a			
				action plans are developed a threshold of 95% is not met			
				ensure continual compliance			
				Non-compliance with facility policy and procedure may re	eult		
				in employee re-education an			
				disciplinary action.			
				· The Director of Nursin	g		
				Services or her designee is responsible to monitor for			
				compliance.			
	1		1	1	i		

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Event ID: 2XHN11

Facility ID: 000072

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	00 	COMPLETED 02/22/2013		
		VING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Compliance Date: March 24, 2013			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN11

Facility ID: 000072

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS CITY STATE ZIP CODE		
	ROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance			
	committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.			
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to ensure the quality assessment and assurance committee identified and implemented an appropriate plan of action related to monitoring psychoactive medications and ensuring there was an indication for the use of the medication. This had the potential to affect 4 of 10 residents reviewed for unnecessary medications. (Residents #61, #65,	F0520	F520 QAA Committee-Members/Me Quarterly/Plans It is the practice of this provider to ensure the quality assessment and assurance committee identifies and implements an appropriate plan of action related to monitoring psychoactive medications and ensuring there is an indication for the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN11

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If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	BUILDING COMPLETED		COMPLETED	
		155152	B. WIN			02/22/2013	
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE	
	#87 and #131)				use of the medication.		
	Findings include	do:					
	Findings includ	ie.					
	1 Interview w	ith the Executive			What corrective action(s) will	1	
		22/13 at 2:00 p.m.,			be accomplished for those residents found to have been	,	
		•			affected by the deficient	•	
	indicated the facility was focusing on Gradual dose reductions for				practice?		
		nedications and not					
	1	uch on monitoring					
	behaviors for residents who were receiving psychoactive medications and ensuring there were indications				The physician orders for		
					residents #87, #61, #65, and #130 a	are	
					being followed.		
	for the use of p				Resident #131 no longer res	ides	
	medications.	, , , , , , , , , , , , , , , , , , , ,			in the facility.	1400	
	2. Observation	n and interview of			 The consultant pharmacist reviewed Residents #87, #61, #65, a 	and	
		on 2/18/13 at 2:00 p.m.,			#130 medications to ensure that th		
		esident was alert to			are free from unnecessary drugs, making recommendations as neede	ا ا	
	person, place a	and time. The resident			making recommendations as neede	u.	
		propriately to several			· Residents #87, #61, #65, an	d	
	questions and	provided good insight			#130 medication regimens are reviewed routinely for a gradual dos		
	to answers.				reduction as required per state	•	
					regulation.		
	The record for	Resident #87 was			The Executive Director has		
	reviewed on 2/	20/13 at 11:00 a.m.			ensured the monitoring of psychoac	tive	
	and indicated t	the resident was			medications and assurance of an		
	admitted in Jul	y 2012 with diagnoses			indication for the use of the medicat has been addressed through the	ion	
	including, but r	not limited to: dementia			QAA/CQI process and a plan of acti		
	with behaviora	l disturbance, dementia			has been developed and implement	ed.	
	with delusions,	, depression and					
	anxiety. The physician orders						
	indicated the re	esident received					
	Risperdal (an a	anti-psychotic					
	medication) 0.3	25 milligrams (mg) in			How will you identify other		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED	
		155152	A. BUI. B. WIN			02/22/2013	
			P. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			MAIN ST		
	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	_	isperdal 0.25 mg in the			residents having the potentia	al	
	evening and Lexapro (an anti-depressant medication) 10 mg				to be affected by the same deficient practice and what		
					corrective action will be take	nn2	
	every day.				corrective action will be take	····	
	The Admissis	n Minimum Data Set					
					Residents receiving		
	, ,	ment, dated 8/1/12,			psychoactive medication have the		
		ef Interview for Mental			potential to be affected by the allege	ed	
	, ,	of 13/15, indicating			deficient practice.		
	_	ive deficit. The MDS			A consultant pharmacist revi	ews	
	indicated the re				each resident's medication regimen		
		ood problems and			routinely but no less than monthly to		
	-	sychotic drugs and an			ensure that they are free from unnecessary drugs, making		
	antidepressant	t seven days a week.			recommendations as needed.		
	Th - 40/07/40	4/40/40 O			Residents receiving		
		and 1/18/13, Quarterly			psychoactive medication are		
		ents, indicated a BIMS			reviewed routinely for a gradu	al	
	,	ognitive deficit) and no			dose reduction as required pe	l l	
		nood problems. The			state regulation.		
	resident contin				The Oreston Deep		
		lrugs seven days a			The Gradual Dose Reduction tracker will be upda	ated	
	week and an a	intidepressant seven			with an audit of appropriate ca		
	days a week.				plans showing clear indication		
					for use for each resident		
	Interview with	the Social Service			receiving a psychoactive		
	Director (SSD)	on 2/20/13 at 2:27			medication.		
	` ′	when the resident was			. Pooldonto will be referre	ad	
		e facility, the resident's			 Residents will be referred for discontinuation or Gradual 		
		asked why the resident			Dose Reduction of psychoacti		
		the drugs and he			medication that does not have		
	_	s due to delusions. The			clear indication of use, identifi		
	SSD indicated				through monthly behavior		
					summaries and meetings.		
	-	logical interventions			Neede will be tileage in		
		rage activities and the			Needs will be identified through COI review, chart		
	i resident's hust	oand took her out for			through CQI review, chart	ĺ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00		COMPLETED	
		155152	B. WING			02/22/2013	
			P. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	short stays. Th	e SSD reported the			reviews, or monthly behavior		
	facility used me	onthly flow sheets to			reviews will be addressed thro	ough	
	monitor the res	sident's behaviors.			CQI communication forms.		
	Review of the	monthly flow sheets for			· Social Service is		
		2, January 2013 and			responsible to review resident		
		, indicated the resident			behaviors with the		
		nt of verbal distress in			Interdisciplinary Team at the		
	December 201				clinical meeting Monday-Frida	у	
		- .			(excluding holidays). The		
	Popord rovious	indicated there were			resident's plan of care is revie	wed	
					and revised, as needed. Significant resident behaviors	are	
		raindications listed as			reported to the nurse		
	, , ,	choactive drugs could			manager-on-call on the		
	not be reduced	l.			weekends and holidays, as		
					needed, to ensure resident ne	eds	
		11:00 a.m., the			are met.		
	Executive Dire	ctor was informed of			The Charge Nurse is		
	the concerns re	egarding the continued			 The Charge Nurse is responsible to follow-up on 		
	use of the psyc	choactive drugs and			consultation orders as needed		
	requested any	additional information					
		indicated the resident			· The Interdisciplinary Team		
		n by the psychological			reviews Physician Orders and the 24	•	
	_	ad seen before			Hour Report, to ensure pertinent ord are referred to the appropriate	ers	
		ne facility. A request			departments. The orders from the		
		ne progress notes.			weekend are reviewed on the next		
	was made of the	ic progress notes.			business day. The manager on duty		
	On 2/22/12 at	11:20 a m the Director			notified by the charge nurse of pertir information on the weekends and	ICIIL	
		11:30 a.m., the Director			holidays, as needed.		
	_	informed of the lack of					
	_	arding the continued			The Executive Director will		
		choactive drugs and			ensure the monitoring of psychoacting medications and assurance of an	ve	
	' '	additional information			indication for the use of the medicati	on	
	available.				is being addressed through the		
					QAA/CQI process and a plan of action has been developed and implemented	•	
	On 2/22/13 at	1:30 p.m., the SSD			nas seen aevelopea ana implement	ou.	
		vior flow sheets which					
	l •	Section D of the MDS					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING		(X3) DATE SUR COMPLETE 02/22/20	ED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹			MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE CO	OMPLETION
TAG		other information was		TAG	BEIGERCI)		DATE
	provided to income being seen by or that the drug continued need	licate the resident was psychological services gs were reviewed for d.			What measures will be put i place or what systemic changes you will make to ensure that the deficient practice does not recur?	nto	
	reviewed on 2/2 Physician's ord indicated the re Ativan (an anti 0.5 milligrams administered of A Physician's of indicated the re Seroquel (an amedication) 50 mg in the more Interview with Director on 2/2 indicated the Americated the American the Ameri	on an as-needed basis. Forder dated 11/21/12, esident was to receive enti-psychotic org at bedtime and 25 hing. The Social Services field 3 at 8:55 a.m., extivan was used to treat or Seroquel was an entire Beruary 2013 ministration Record fiagnoses, which were not limited to, earkinson's, Depression, esorder, Worsening of ehaviors with formnia, anxiety. Review			Staff has been re-inserviced on completing to new/worsening behavior ever prior to PRN psychoactive medication use or a new order psychoactive medication by Social Services by March 24, 2013. Social Services and the Interdisciplinary Team will conduct chart reviews of those residents prescribed psychoat medication to determine the appropriateness of use and interventions. Within the first 5 days of admission Social Services will review resident's psychoactive medication to determine past and present behaviors/moods exhibited and appropriate diagnosis and indication use. A comprehensive care plan we created for assessment and tracking the medication. A consultant pharmacist reviews than monthly the neutron that they are free from	er for ee ee ective ew a use n for ill be g of	
	Alzheimer's, B Delusions, Inso of the resident	ehaviors with			each resident's medication regimer routinely but no less than monthly t	n	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155152				02/22/	2013
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹					
MONITIC		IVING AND LIEAL TUGADE	1120 N MAIN ST MONTICELLO, IN 47960				
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	GELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	for symptoms	of depression. Review			· Residents receiving		
	of the Decemb	er 2012, January and			psychoactive medication are	al	
	February 2013	Medication			reviewed routinely for a gradu dose reduction as required pe		
	Administration	Records, indicated			state regulation.	1	
	Ativan was not	needed as an					
	intervention in	over 60 days. The			· The Gradual Dose		
		indicate the continued			Reduction tracker will be upda		
		lication was justified.			with an audit of appropriate ca		
		medien was jasansa.			plans showing clear indication	IS	
	Further intervie	ew with the Social			for use for each resident receiving a psychoactive		
					medication.		
		or, indicated the facility			medication.		
		a new system in the			· Residents will be referre	ed	
	l '	reassessing for the			for discontinuation or Gradual		
		ations as behavioral			Dose Reduction of psychoacti		
	interventions.	The Social Service			medication that does not have		
	Director preser	nted Behavior Flow			clear indication of use, identifi	ed	
	sheets and ind	icated monthly review			through monthly behavior summaries and meetings.		
	meetings were	starting, but there was			summanes and meetings.		
	_	ere had been ongoing			Needs will be identified		
		of the resident's use of			through CQI review, chart		
	psychoactive r				reviews, or monthly behavior		
	1	e Social Service			reviews will be addressed thro	ough	
		ted, "We do not do			CQI communication forms.		
		pression. We do Care			· Social Service is		
	_				responsible to review resident		
		look in Nurses' notes			behaviors with the		
		new and worsening			Interdisciplinary Team at the		
	behavior."				clinical meeting Monday-Frida	ıy	
					(excluding holidays). The		
		n on 2/18/13 at 12:20			resident's plan of care is revie	wed	
	p.m., during lu	nch, staff were unable			and revised, as needed.	oro	
	to get Residen	t #61 to open his eyes			Significant resident behaviors	are	
	while sitting at	the lunch table. The			reported to the nurse manager-on-call on the		
	resident had b	een observed sitting			weekends and holidays, as		
	with his eyes o	•			needed, to ensure resident ne	eds	
	1	the late morning prior			are met.		
	1	and the month of prior	1				l

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		LDING G	ONSTRUCTION 00	(X3) DATE S COMPLI 02/22/ 2	ETED
NAME OF F	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
	involved in action 2/19 at 11:0 2:45 p.m., four dayroom sitting eyes closed. Review of Res 2013 Medication Record (MAR) a.m., indicated diagnoses, inclimited to, Alzh hypertension, meningeoma, with agitation, MAR, indicated receiving Mela supplement for (mg) daily at be the Social Servat 8:55 a.m., in was used to tree	luded but were not eimer's with tremors, chronic constipation, insomnia, dementia and depression. The dithe resident was tonin (an herbal sleep) 5 milligrams edtime. Interview with vice Director on 2/22/13 indicated the Melatonin eat insomnia.		The Charge Nurse is responsible to follow-up on consultation orders as needed. The Interdisciplinary Team reviews Physician Orders and the 2-Hour Report, to ensure pertinent orders referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on dut notified by the charge nurse of pertiniformation on the weekends and holidays, as needed. The Executive Director will ensure the monitoring of psychoactismedications and assurance of an indication for the use of the medicatis being addressed through the QAA/CQI process and a plan of actinas been developed and implement. Non-compliance with facility policy and procedure more sult in employee re-education and/or disciplinary action.	4 ders y is nent ve ion ed.	
	1/31/13, indica interventions for management,	care plan updated on ted the following or Insomnia; pain reposition, and ident to be awake in		How the corrective action(s) will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place.	the cur,	
	Service Director had just began	ew with the Social or, indicated the facility a new system in the reassessing for the		The CQI tools "Psychoactive Management, Behavior Management, SS Ca Plan and Unnecessary Medications" will be utilized by		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) M		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED	
		155152	B. WIN			02/22/	2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	R			MAIN ST			
MONTIC	FILO ASSISTED I	IVING AND HEALTHCARE			CELLO, IN 47960			
			1					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE	
		ations. The Social			Interdisciplinary team weekly	_		
		or presented Behavior			times four, monthly times three and quarterly thereafter for at	5		
	Flow sheets ar	nd indicated monthly			least six months to ensure			
	review meeting	gs were starting, but			compliance with assessment a	and		
	there was no e	vidence there had			documentation procedures.			
	been ongoing i	reassessment of the						
	resident's use	of Melatonin. The			· The CQI committee			
		Director indicated the			reviews the audits monthly and			
		no insomnia last month			action plans are developed as threshold of 95% is not met to			
		The Social Service			ensure continual compliance.			
		ted no meeting with the			Non-compliance with facility			
		yet occurred to			policy and procedure may resu	ult		
	l · •	esident's need for the			in employee re-education and	or/		
		esident's need for the			disciplinary action.			
	medication.							
		for Resident #131 was			The Executive Director	or		
	reviewed on 2/	22/13 at 3:27 p.m. The			her designee is responsible to			
	Minimum Data	Set (MDS)			monitor for compliance.			
	assessment da	ated 12/18/12, indicated			·			
	the resident wa	as diagnosed with "mild						
		th no behaviors and						
		rief Interview for			Compliance Date: March 24,			
		score of 13. Review of			2013			
	,	013 Physician orders						
		S), indicated diagnoses						
	1	not limited to, Chronic						
		Imonary Disease,						
	· ·	r Cancer, Dementia,						
		state, Falls, acute						
		Epilepsy, Dementia with						
	Delusions, Anx	•						
		ny and Insomnia. The						
	POS indicated	the resident was						
	prescribed Tra	zadone (an						
	l ·	it) 50 milligrams (mg) 1						
	•							

	OF CORRECTION OF CORRECTION 155152	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/22/2013		
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	hour before bedtime, Namenda (a medication to treat Alzheimer's) 5 mg twice daily, Diazepam (an anti-anxiety medication) 5 mg twice daily, and Paroxetine (an antidepressant medication) 20 mg in the morning and 10 mg in the evening. A 2/15/13 Physician's progress note, indicated the resident had also been receiving Remeron (an anti-depressant) but it was discontinued because the resident "states that he feels too sedated (since starting Remeron)." Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for "the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. However, the January 2013 and February 2013 Behavior Tracking Flow Sheets, indicated those behaviors had not been exhibited since the care plan was initiated. There was no indication in the resident's record indicating an assessment had been completed to determine a need for the medications. Further, the resident's record did not contain a Care Plan for depression nor justification as to why the medications used to treat depression					

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Event ID: 2XHN11

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
MOLLAN	or connection	155152		LDING		02/22/	
		100102	B. WIN		DDDDGG GYRY GRAND GYD GODD	OZIZZI	2010
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	were required.						
	Interview with to Director on 2/2 indicated there written for symand she indicated find out why the	the Social Service 2/13 at 8:55 a.m., was no care plan ptoms of depression ted she would need to e resident was on sed to treat depression.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN11

Facility ID: 000072

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE COMPL 02/22 /	ETED	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
R0241	the provision of rebe as ordered by and shall be supe on the premises of (1) Medication shicensed nursing medication aides. Based on recording medication pressure administration. to affect the five diabetics who recive the five diabetics who recive wed on 2/2 resident's diagram were not limited hypertension, or chronic kidney artery disease. Review of the Financial Statement (PO indicated the reblood sugar characteristic provides and provi	Offense ation of medications and esidential nursing care shall the resident 's physician ervised by a licensed nurse or on call as follows: all be administered by personnel or qualified or dreview and accility failed to ensure cribed medications ered as ordered for 1 of dents related to insulin This had the potential erinsulin dependent esided on Assisted ent #5) e: Resident #5 was 22/13 at 1:20 p.m. The moses included, but do diabetes mellitus, obesity, stage III disease, and coronary	R02	41	R241 Health Services It is the practice of this provider to ensure that physician prescribed medications are administered as ordered related to insulin administration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5's physician was contacted to clarify the insulin orders. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked.	al	03/24/2013	

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		DING 00		COMPLETED	
155152		B. WIN			02/22/20	013		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1120 N	MAIN ST			
MONTICELLO ASSISTED LIVING AND HEALTHCARE					CELLO, IN 47960			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	,	<u> </u>	DATE	
	_	ne following scale:			Assisted Living with insulin administration orders have the	,		
	_	'0-100, no coverage;		potential to be affected by the		, l		
	111-151, 1 unit; 151-200, 2 units; 201-250, 4 units; 251-300, 6 units;				alleged deficient practice.			
	-	ts; 351-400, 10 units;			· All residents on Assisted			
	and greater than 500, 12 units and				Living who have insulin orders			
	call the physic	ian.			had their orders audited for accuracy.			
	Review of the	January 2013 Capillary						
		Monitoring Tool,						
		/8/13 at 11:30 a.m., the			What measures will be put ir	ito		
		d sugar was 411, the			place or what systemic			
		red 10 units of insulin.			changes you will make to			
	There was no				ensure that the deficient			
		ny insulin coverage.			practice does not recur?			
	On 1/10/13 at	-						
		•						
	resident's blood sugar was 189. The resident did not receive any insulin. The resident should have received 2				· Re-education for nurses was			
					given by the SDC by March 24, 201	3.		
					Pland Cluppes manitor	ina		
		1/13 at 4:00 p.m., the			Blood Glucose monitor flow sheets for Assisted Living	-		
	resident's blood sugar was 305. The resident received 9 units of insulin and she should have received 8 units				residents with insulin orders h			
					been added to the Diabetic			
		u nave received o units			Monitoring book for the BCD ι	ınit.		
	of insulin.				The Heit Manager and he	_		
	Davies 60	DOO for Follow			 The Unit Manager or he designee is responsible to aud 			
		POS for February			this book daily.	411.		
	· ·	d the resident was to						
		d sugar checked four			· Non-compliance with			
	times a day, before meals and at bedtime. She was to receive Novolog (insulin, medication used to treat high blood sugars) according to the following scale: blood sugars 70-100,				facility policy and procedure m	-		
					result in employee re-education	n		
					and/or disciplinary action.			
	no coverage; 1	l11-151, 1 unit;			How the corrective action(s)			
	151-200, 2 uni	ts; 201-250, 4 units;			will be monitored to ensure t	he		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI		00	COMPLETED	
155152		B. WIN			02/22/2013		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1120 N	MAIN ST		
MONTICELLO ASSISTED LIVING AND HEALTHCARE					CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	· ·	ts; 301-350, 8 units;			deficient practice will not rec	ur,	
	351-400, 10 ur	nits; and greater than			i.e., what quality assurance	•	
	500, 12 units, a	and call the physician			program will be put into plac	er	
	for blood sugar	rs less than 60 or					
	greater than 50	00.					
					· The CQI tool titled "Insu	ilin	
	Review of the	February 2013			Administration Monitoring" will	II.	
		d Glucose Monitoring			utilized by the Interdisciplinary		
		on 2/4/13 at 4:00 p.m.,			team weekly times four, month	ıly	
		plood sugar was 228.			times three and quarterly thereafter for at least six mont	he	
		eceived 12 units of			to ensure compliance with	115	
		ould have received 4			assessment and documentation	on	
		. On 2/6/12 at 6:00			procedures.		
		ent's blood sugar was			· The CQI committee		
		dent did not receive any			reviews the audits monthly and	II.	
		e should have received			action plans are developed as threshold of 95% is not met to		
		in. On 2/8/13 at 11:30			ensure continual compliance.		
		ent's blood sugar was			Non-compliance with facility		
		ent received 12 units of			policy and procedure may resu	ult	
	insulin. There	was no physician's			in employee re-education and	or or	
	order for insuli	n to be given. On			disciplinary action.		
	2/12/13 at 6:00	a.m. the resident's			. The Director of Nursing		
	blood sugar wa	as 243. The resident			 The Director of Nursing Services or her designee is 		
	received no ins	sulin and she should			responsible to monitor for		
	have received	4 units of insulin. On			compliance.		
	2/15/13 at 6:00	a.m., the resident's					
		as 469. The resident					
	_	its of insulin. There			Ormaliana B. C. M. J. C.		
		rom the physician for			Compliance Date: March 24, 2013		
		rerage. At 4:00 p.m.,			2013		
	1	plood sugar was 216.					
		eceived no insulin and					
		ve received 4 units of					
		esident's blood sugar on					
	2/16/13 at 6:00	a.m. was 411. The					

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	of correction (X1) Provider/supplier/clia (IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2013			
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				
	resident received 12 units of insulin There was no order from the physician for any insulin coverage. On 2/19/13 at 11:00 a.m., the resident's blood sugar was 470. The resident received 10 units of insulin. There was no order from the physician for any insulin coverage. On 2/20/13 at 6:00 a.m., the resident's blood sugar was 180. The resident did not receive any insulin and she should have received 2 units of insulin Interview with the Director of Nursing on 2/22/13 at 5:30 p.m., indicated a call had been made to the physician to clarify what insulin coverage the resident should receive when her blood sugars were between 401 and 500. There was no other information provided.						

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